

preceptors, better charge nurses and more informed about complex patient issues. Several specific examples will be highlighted. The goal of this presentation is to show how an informal discussion can lead to improved compliance & enhanced patient care in the adult stem cell transplant patient population.

455

GETTING TO KNOW THE UNDERLYING DISEASES OF STEM CELL TRANSPLANTATION PATIENTS: A NURSING REFERENCE

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Nursing practice in Stem Cell Transplant (SCT) is characterized by delivering complex care to patients who are on a variety of dynamic protocols. SCT is used as a treatment option for patients with various underlying diagnoses. Often, because of the intense knowledge required to care for the SCT patient, nurses become so focused on the transplant process that they miss needed information about the underlying diagnoses and previous treatment processes patients present with.

To address this information gap, a comprehensive reference chart was developed to identify primary disease processes for which patients are most often recipients of SCT. The chart serves as an easy to use clinical reference for nurses including information on diagnoses, treatment regimens and common associated complications. In addition to bridging the knowledge gap for clinical nurses, the chart also serves as a resource for answering patients' questions about how transplant relates to their underlying disease. The information supports nurses in identifying complications that may occur in relation to the primary treatment and conditioning regimens, as well as stem cell transplant.

The reference chart was developed by two clinical nurses in collaboration with the clinical nurse specialist. Extensive research was done using current references and resources, with the addition of quality control done by appropriate physicians and nurse practitioners. The charts are kept in patient care binders for easy access on the unit.

A survey is currently being conducted to assess the helpfulness of the chart, easiness of use, and to determine if it has aided in improving patient/nurse relationships and outcomes. Results will be shared.

Such a reference has applicability in both inpatient and outpatient transplant settings and may also be useful in medical/hematology oncology practice settings.

456

MEDICAL RESPONSE TO RADIATION EMERGENCY: THE ROLE OF THE HEALTHCARE PROVIDERS

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In the wake of 9/11 and other terrorist attacks, Homeland Security and DOD have been assessing potential threats to the USA. A nuclear attack of significant level is high on the probability list. In addition, the potential for several different types of nuclear or radiological accidents continue to cast a shadow over our wellbeing. This discussion will focus on the purpose and entity of the Radiation Injury Treatment Network system, discuss the impetus for its creation, consider basic radiation education, detail the signs and symptoms, diagnosis, and treatment of Acute Radiation Sickness, which will include a discussion of the role of transplant, and then pursue our responsibility and role in the RITN system as prepared transplant providers.

RITN is a partnership of the NMDP, collection centers, both primary and tertiary transplant centers, and cord blood banks across the nation that have agreed to form a network as a means of educating providers about their potential involvements in response to a radiation event, provide comprehensive evaluation and treatment for victims of radiation exposure or other marrow toxic injuries, create treatment guidelines, conduct readiness exercises, and coordinate situation responses (RITN mission statement).

The need for such a network is evidenced by threat planning by the US government. The number one threat listed by the government is a 10-kiloton Improvised Nuclear Device explosion. Number eleven on their list is a radiological dispersal device, or "dirty

bomb" explosion. The aftermath of such an attack could result in large numbers of people exposed to detrimental amounts of radiation, likely cumulating in acute radiation sickness. Mortality from ARS may be decreased if, through accurate triage and cooperation among centers, the subset of the population exposed to detrimental doses of radiation can be given either supportive care until recovery, or identified and transitioned on to "emergent stem cell transplant." As healthcare providers in the transplant setting, we need to be aware of the systems being created and to the role we may be asked to play. While not first responders, we would likely be asked to provide care to larger numbers of patients than normal and to act in supervisory roles under an altered standard of care protocol. Above all, we need to be reminded to remain flexible, in order to create the best milieu in which to assist as many patients as possible during a crises.

457

CHEMOTHERAPY SAFETY INITIATIVE: IMPLEMENTATION OF "NO INTERRUPTION" ZONES FOR CHECKING CHEMOTHERAPY

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In August of 2008, the Blood and Marrow Transplant unit at Stanford Hospital joined the Intergrated Nursing Leadership Program (INLP). The purpose of this project was to look at medication administration from the beginning of the medication pass to its completion. Audits were done on each unit using six "best practice" criteria as identified by the California Nursing Outcomes Coalition (CalNOC). The results of the audits were used to identify areas where the unit scored the lowest and to devise solutions to improve these areas.

A four nurse team from the Blood and Marrow Transplant unit was trained to follow nurses performing their medication passes. Each medication administration was evaluated for the following six criteria; did the RN compare the medication to the MAR, were there distractions or interruption, was the medication labeled throughout the entire medication pass, were 2 forms of patient ID checked, was the medication explained to the patient and was the medication charted immediately after the administration. 100 audits were performed in September 2008, followed by 20 audits per month until September 2009, when an additional 100 audits were completed.

Monthly data was scored and the results were provided to the Blood and Marrow Transplant unit. The unit team was then responsible to come up with one "test of change" for the unit. This change was based on the "best practice" criteria that had received the lowest score. The team decided to work on reducing interruptions during chemotherapy checks and administration. To achieve this goal, three computers on the unit were designated as "No interruption" zones. These areas have a bright yellow sign that states "STOP! No interruptions allowed, chemo check in progress". Additionally, a red LCD light was placed on the top of each computer and is turned on during chemo checks and again in the patients room during the administration of the chemotherapy.

When the "test of change" was first initiated, the nurses had to be reminded to use the zones and lights. Other staff had to be reminded to honor the "No Interruption" zone and lights. The staff feels that the "No interruption" zones allows chemotherapy to be calculated and administered in a safe and efficient manner. We have recently achieved several month of 100% compliance. The team will continue to monitor the data and look at other ways to improve patient safety while preparing and passing medications.

458

RN EDUCATION ON STANFORD BLOOD AND MARROW TREATMENT AND RESEARCH PROTOCOLS

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Purpose: Keeping nurses up to date on treatment and research protocols.

Methods: Our large academic Blood and Marrow Transplant (BMT) Program has 10 active treatment plans and 27 research protocols. These are not static numbers as new studies are opened and others complete accrual. As a result, keeping up to date is